



HIV/AIDS Monitoring Report

Department of Health and Human Services

Data through June 30, 2002

The mission of the City of Long Beach Department of Health and Human Services is to improve the quality of life of the residents of Long Beach by addressing the public health and human service needs ensuring that the conditions affecting the public's health afford a healthy environment in which to live, work and play.

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HIV Stops With Me in Long Beach

The City of Long Beach Department of Health and Human Services (LBDHHS) recently launched its *HIV Stops With Me* social marketing campaign with great community support. With grant funding provided by the State Department of Health Services Office of AIDS, the Long Beach DHHS contracted with Better World Advertising, a San Francisco-based social marketing firm that uses marketing and advertising techniques to promote non-commercial social causes, to bring the *HIV Stops With Me* campaign to Long Beach. Originated in San Francisco, this campaign has been replicated in Boston and was recently adapted for use in Los Angeles and Orange counties, including the cities of Long Beach and West Hollywood.

The overall goal of the *HIV Stops With Me* campaign is to promote strategies that support HIV infected individuals in their efforts to be leaders in HIV prevention. The Long Beach campaign consists of a website (www.hivstopswithme.org), billboards, newspaper and magazine advertisements, postcards, and posters displayed in local bars, clubs, and restaurants.

In collaboration with Better World Advertising, the Long Beach DHHS identified four individuals representing the unique challenges, hopes, fears and successes faced by HIV+ persons trying to prevent the further spread of HIV to serve as campaign spokes models.

The spokesmodels were also chosen to reflect the demographic makeup of the Long Beach community and local HIV epidemic. Long Beach AIDS surveillance data indicates that the majority of reported cases are in White males. However, Black and Hispanic males collectively account for about a third of the City's AIDS cases. Male-to-male contact continues to be the leading exposure category among local AIDS cases. Intravenous drug use and male-to-male contact combined with intravenous drug use make up about a fifth of the City's AIDS cases by exposure category. Of the four male spokesmodels chosen to represent the City of Long Beach in the *HIV Stops With Me* campaign, two are White, one is Black and one is Puerto Rican. The four spokesmodels identify as either gay

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or bisexual and two have histories of drug abuse.

In addition to appearing in print advertisements, each spokesmodel has their own section of the website where they tell their story and engage in an online dialogue with members of the community. The spokesmodels share their diverse experiences and opinions about living with HIV and how they are leading the effort to end new infections. There is an "issue of the month" section where each spokesmodel gives his take on an array of topics. Recent issues of discussion have addressed their roles in protecting their partners, dealing with "bug chasing" and when (or when not) to disclose their HIV status. The website also contains articles of interest, resources, and a calendar of related events.

The campaign will run through the end of this year and then, based on evaluation data, will hopefully continue.

HIV EPIDEMIOLOGY PROGRAM

Introduction

Comprising nearly 50 square miles at the southernmost end of Los Angeles County, Long Beach has approximately a half-million residents, making it the fifth largest city in California and the 32nd largest in the United States (based on 2000 LACo. Urban Research Unit). One of 61 health jurisdictions in California, the City of Long Beach has maintained the Health Department for more than 90 years.

Its size, diversity and geographic location in a major population center have made Long Beach particularly vulnerable to HIV and AIDS. With a cumulative incidence rate of 924.98 AIDS cases per 100,000 residents (1981 through June 30, 2002), Long Beach's AIDS incidence rate per capita is 100 percent higher than the incidence rate for all of Los Angeles County (448.27 cases per 100,000) and more than double the rate for the State of California overall (366.52 cases per 100,000), indicating that AIDS continues to be a significant public health issue in the City of Long Beach (Table 1).

TABLE 1

COMPARISON OF CITY OF LONG BEACH, LOS ANGELES COUNTY AND CALIFORNIA CUMULATIVE AIDS INCIDENCE RATE PER 100,000 POPULATION, 1981 THROUGH JUNE 30, 2002.

	2000 Population	Number of AIDS Cases	Cumulative AIDS Incidence Rate
City of Long Beach	450,603	4,168	924.98
Los Angeles County	9,884,300	44,308	448.27
California	34,336,000	125,848	366.52

Sources: California HIV/AIDS Reporting System, June 30, 2002
Long Beach HIV/AIDS Reporting System, June 30, 2002

The California Code of Regulations, Title 17, Section 2500, requires that all diagnosed or suspected cases of AIDS as defined by the Centers for Disease Control and Prevention (CDC) be reported within seven days to the local Health Officer. To facilitate reporting, the City of Long Beach Department of Health and Human Services maintains an HIV Epidemiology Program (funded by the State of California Department of Health Services Office of AIDS) which is responsible for collecting, analyzing and disseminating AIDS data.

Cumulative Cases

Since its first AIDS case report in February 1983, a cumulative total of 4,168 AIDS cases has been reported in Long Beach through June 30, 2002. The cumulative case fatality rate of 58 percent is similar to California (61 percent) and Los Angeles County (62 percent). Of the 4,168 reported AIDS cases, 1,738 people are currently living.

Race/Ethnicity

Of the 4,168 cumulative AIDS cases, approximately two-thirds (62.2 percent) are White (Table 2). While Whites still comprise the majority of the reported cases, the number of HIV infections may be decreasing in this group. From July 2001 through June 2002, the percentage of AIDS cases reported in Whites was 47.3 percent. AIDS cases in Blacks, while contributing 17.3 percent to the cumulative cases, comprised 21.9 percent of the cases reported in the past year. Hispanic AIDS cases comprised more than one-quarter (27.0 percent) of the cases reported in the last year, yet they make up 18.4 percent of the cumulative cases. The percentage of cases among Asian/Pacific Islanders during the past year (3.5 percent) is higher than the 1.8 percent reported cumulatively (Table 2).

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TABLE 2

CUMULATIVE AIDS CASES BY RACE/ETHNICITY AND PERCENT OF POPULATION REPORTED 1981 THROUGH JUNE 30, 2002, CITY OF LONG BEACH

	2000 Population	Percent of Population	Number of AIDS Cases	Percent of AIDS Cases
White, Not Hispanic	160,452	35.6%	2,593	62.2%
Black, No Hispanic	68,443	15.2%	721	17.3%
Hispanic	142,049	31.5%	765	18.4%
Asian/PI	77,227	17.1%	76	1.8%
Amer.Ind./Alaska Nat.	2,432	0.5%	11	0.3%
Not Specified*			2	<0.1%
TOTAL	450,603	100%	4,168	100%

* These cases are pending investigation. Upon identification of race/ethnicity, cases will be reclassified into appropriate category.

Gender

The vast majority of AIDS cases in Long Beach are male (94.0 percent). However, the increasing percentage of female AIDS cases being reported each year suggests that more women may be becoming infected. During July 1, 2001 - June 30, 2002, 9.6 percent of the cases reported were in females, compared with a cumulative percentage of 6.0 for cases reported as of June 30, 2002 (Table 3).

Age

TABLE 3

AIDS CASES BY REPORT DATE AND GENDER, REPORTED JULY 1, 2001 THROUGH JUNE 30, 2002, AND CUMULATIVE TOTALS THROUGH JUNE 30, 2002, CITY OF LONG BEACH.

	July 2001 – June 2002	1981 – June 2002
Male	206 (90.4%)	3,912 (94.0%)
Female	22 (9.6%)	256 (6.0%)
TOTAL	228 (100%)	4,168 (100%)

Through June 30, 2002, almost half (48.2%) of the cumulative AIDS cases in Long Beach were diagnosed among people between the ages of 30 and 39. More than one-quarter of all cases were diagnosed among people between the ages of 40 and 49. This indicates that the majority of people with AIDS in Long Beach were infected in young adulthood. Fifteen percent of AIDS cases were diagnosed in people in their twenties, suggesting that a significant number of people with AIDS became infected during adolescence (Table 4).

TABLE 4

CUMULATIVE AIDS CASES BY AGE GROUP AND GENDER, REPORTED 1981 THROUGH JUNE 30, 2002, CITY OF LONG BEACH.

	No. of Male Cases	No. of Female Cases	TOTAL
Under 13	5 (0.1%)	4 (1.6%)	9 (0.2%)
13-19	7 (0.2%)	6 (2.3%)	13 (0.3%)
20-29	583 (15.0%)	60 (23.4%)	643 (15.4%)
30-39	1,909 (48.8%)	99 (39.0%)	2,008 (48.2%)
40-49	1,018 (26.0%)	60 (23.4%)	1,078 (26.0%)
Over 49	390 (10.0%)	27 (11.0%)	417 (10.0%)
TOTAL	3,912 (100%)	256 (100%)	4,168 (100%)

Exposure Category

Eighty-one percent of all adult male AIDS cases reported through June 30, 2002 in Long Beach reported male-to-male sexual contact (MSM) as a mode of transmission. An additional 9.0 percent reported both male-to-male sexual contact and injection drug use (IDU). Nearly seven percent of male AIDS cases reported injection drug use as the sole risk behavior. Over one percent of male cases report being infected through heterosexual contact (Table 5).

Among women in Long Beach, however, heterosexual contact and injection drug use are the prevalent modes of HIV transmission. Of all adult female AIDS cases reported in Long Beach, 54.2 percent were infected through heterosexual contact. Thirty-seven percent were infected through injection drug use. About four percent were infected through the receipt of blood transfusions or blood components, while the remaining cases (4.8%) have reported no risk or are currently under investigation (Table 6).

The predominant mode of HIV exposure in children is perinatal transmission (88.9%) (Table 7).

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TABLE 5
CUMULATIVE ADULT MALE AIDS CASES BY EXPOSURE CATEGORY AND RACE/ETHNICITY, REPORTED 1981 THROUGH JUNE 30, 2002, CITY OF LONG BEACH.

	White	Black	Hispanic	Asian/PI	Am. Ind./Alaka Nat.	Unknown	TOTAL (Row%)
Sex between men	2,144	397	547	62	7	2	3,159 (81.0%)
Sex between men/IDU	229	62	55	1	3	0	350 (9.0%)
Injection Drug Use	107	105	50	0	0	0	262 (6.7%)
Heterosexual Contact	18	21	24	2	0	0	65 (1.7%)
<i>With IDU</i>	4	6	1	0	0	0	11
<i>With Transfusion Recipient</i>	0	0	1	0	0	0	1
<i>With Person with HIV/AIDS</i>	14	15	22	2	0	0	53
Transfusion	6	2	5	1	0	0	14 (0.4%)
Adult Hemophilia	9	1	0	1	0	0	11 (0.3%)
Pediatric Hemophilia	0	0	1	0	0	0	1 (<0.1%)
Risk Not Reported	15	13	15	0	0	0	43 (1.1%)
TOTAL (Column %)	2,528 (64.7%)	601 (15.4%)	697 (17.8%)	67 (1.7%)	10 (0.3%)	2 (<0.1%)	3,905 (100%)

TABLE 6
CUMULATIVE ADULT FEMALE AIDS CASES BY EXPOSURE CATEGORY AND RACE/ETHNICITY, REPORTED 1981 THROUGH JUNE 30, 2002, CITY OF LONG BEACH.

	White	Black	Hispanic	Asian/PI	Other/Unknown	TOTAL (Row %)
Injection Drug Use	25	51	16	0	1	93 (37.0%)
Heterosexual Contact	31	54	45	6	0	136 (54.2%)
<i>With Bisexual Male</i>	7	1	2	0	0	10
<i>With IDU</i>	6	16	9	0	0	31
<i>With Transfusion Recipient</i>	0	0	0	2	0	2
<i>With Hemophiliac</i>	0	1	0	0	0	1
<i>With Person with HIV/AIDS</i>	18	36	34	4	0	92
Transfusion	5	3	1	0	0	9 (3.6%)
Pediatric Hemophilia	0	1	0	0	0	1 (0.4%)
Risk Not Reported	2	8	2	0	0	12 (4.8%)
TOTAL (Column %)	63 (25.1%)	117 (46.6%)	64 (25.5%)	6 (2.4%)	1 (0.4%)	251 (100%)

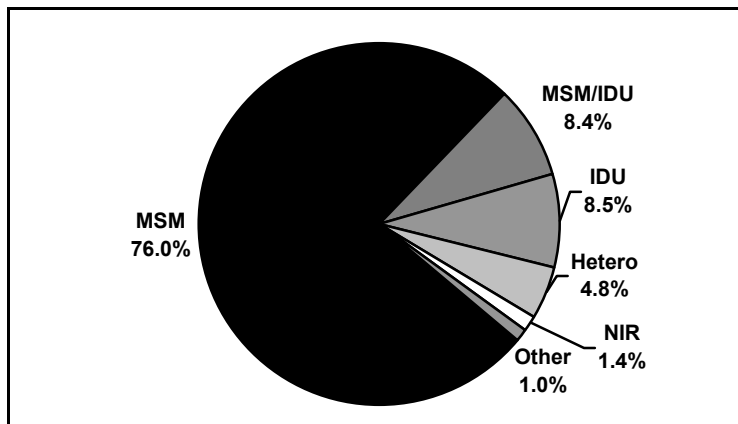
TABLE 7
CUMULATIVE PEDIATRIC AIDS CASES BY EXPOSURE CATEGORY AND RACE/ETHNICITY, REPORTED 1981 THROUGH JUNE 30, 2002, CITY OF LONG BEACH.

	White	Black	Hispanic	TOTAL (Row %)
Mother with Risk	1	3	4	8 (88.9%)
Transfusion	1	0	0	1(11.1%)
TOTAL (Column %)	2 (22.2%)	3 (33.3%)	4 (44.4%)	9 (100%)

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Combined, over three-quarters (76.0%) of Long Beach AIDS cases report sex between men as a risk factor. Almost nine percent report intravenous drug use. Another eight percent report both sex between men and injection drug use. Almost five percent of Long Beach cases report heterosexual contact as the sole risk. Slightly more than one percent of AIDS cases in Long Beach are the result of a blood/blood product transfusion or pediatric transmission. The remaining cases did not report a risk or are currently under investigation to elucidate possible modes of transmission further (Figure 1).

FIGURE 1
CUMULATIVE AIDS CASES BY EXPOSURE CATEGORY, REPORTED 1981 THROUGH JUNE 30, 2002, CITY OF LONG BEACH.



Total Cases = 4,168

Other = Transfusion or transplant recipient, hemophilia, and pediatric cases.

AIDS Defining Conditions

The AIDS surveillance system represents cases that have met the AIDS case surveillance reporting criteria established by the CDC. In 1993, the AIDS surveillance case definition was expanded to include a laboratory measure of severe immunosuppression (CD4+ T-lymphocyte counts of less than 200 cells/ μ l or a percent of total lymphocytes less than 14), pulmonary tuberculosis, invasive cervical carcinoma, and recurrent bacterial pneumonia. Prior to 1993, the surveillance definition included only opportunistic illnesses.

Mortality Rates

Table 8 presents the annual and cumulative fatality rates of AIDS cases reported in Long Beach by the year of diagnosis. The presented rates are comparable to those of Los Angeles County, California, and the United States.

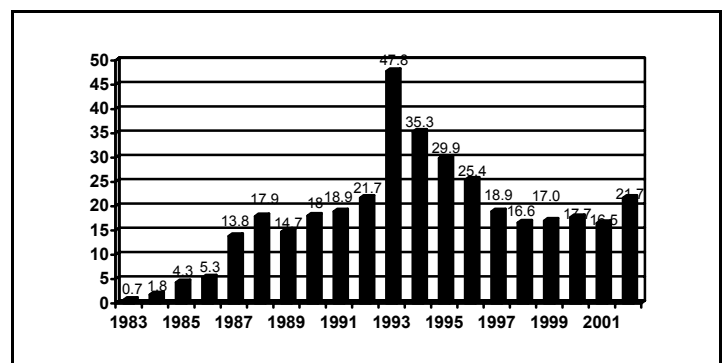
TABLE 8
AIDS CASE MORTALITY BY YEAR OF DIAGNOSIS, REPORTED 1981 THROUGH JUNE 30, 2002, CITY OF LONG BEACH.

Year	Diagnosed Cases	Deaths	Fatality Rate for Cases Diagnosed in Year	Cumulative Fatality Rate
Before 1988	413	406	—	98%
1988	220	217	99%	98%
1989	227	200	88%	96%
1990	295	261	88%	94%
1991	372	316	85%	92%
1992	414	329	79%	89%
1993	362	228	63%	85%
1994	307	152	50%	81%
1995	325	109	34%	76%
1996	278	61	22%	71%
1997	221	42	19%	68%
1998	179	31	17%	65%
1999	199	25	13%	62%
2000	188	30	16%	60%
2001	160	12	8%	58%
2002	47	6	13%	58%
TOTAL	4,207	2,425	—	58%

Impact of Changes in the AIDS Case Definition

The surveillance definition of AIDS was modified in 1985, 1987 and 1993 to reflect increased knowledge of the manifestations of HIV disease. These expanded definitions present challenges in analyzing case trends. For example, expanding the surveillance case definition in 1993 to include HIV-infected individuals with CD4+ T-lymphocyte counts below 200 cells/ μ l resulted in a number of new cases being reported (Figure 2).

FIGURE 2
AVERAGE REPORTED AIDS CASES PER MONTH, REPORTED 1981 THROUGH JUNE 30, 2002, CITY OF LONG BEACH.



Survival Status

By analyzing the data presented in Table 9 and comparing relative proportions of the living and the deceased, changes in the local epidemiology of advanced HIV disease may be detected as living cases are representative of more recent infections. For instance, a higher number of Blacks (21.0%) and Hispanics (24.3%) are currently living with AIDS than are deceased (15.0% and 14.0%, respectively). This demonstrates a shift toward increasing HIV infections in minorities. Similar changes are seen in the gender, age, and exposure categories.

TABLE 9
AIDS CASES BY SURVIVAL STATUS AND DEMOGRAPHICS, REPORTED 1981 THROUGH JUNE 30, 2002, CITY OF LONG BEACH.

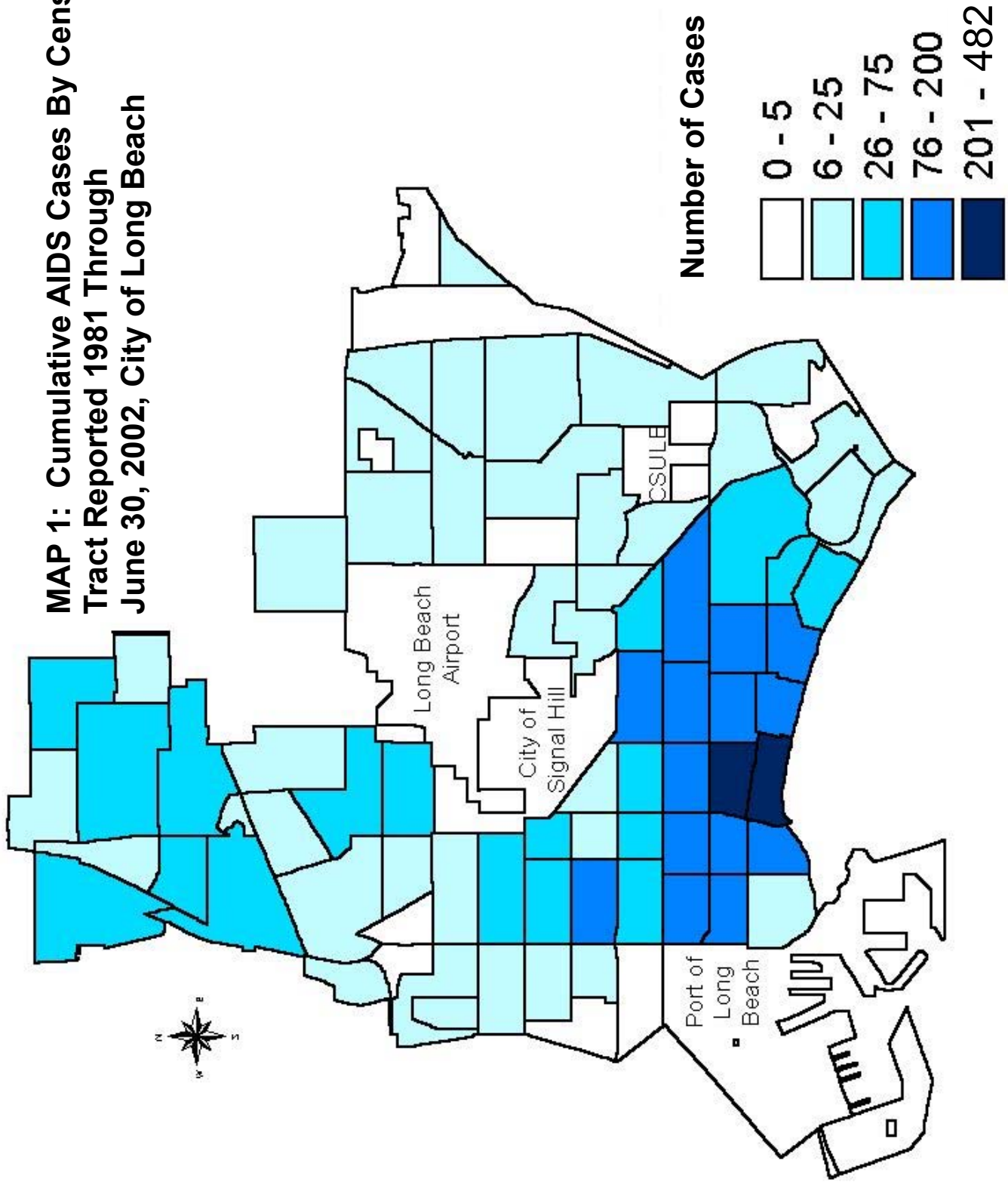
Case Profile	Living	Deceased
Gender		
Male	1,590 (91.5%)	2,317 (96.0%)
Female	148 (8.5%)	107 (4.0%)
Race/Ethnicity		
White, Not Hispanic	910 (52.4%)	1,679 (69.3%)
Black, Not Hispanic	360 (21.0%)	361 (15.0%)
Hispanic	423 (24.3%)	340 (14.0%)
Asian/PI	38 (2.2%)	38 (1.6%)
Am. Ind./Alaska Nat.	7 (0.4%)	4 (0.2%)
Unknown	0 (0.0%)	2 (<0.1%)
Age		
Age <13	3 (0.2%)	6 (0.2%)
13-19	6 (0.3%)	7 (0.3%)
20-29	280 (16.1%)	362 (15.0%)
30-39	861 (49.5%)	1,145 (47.2%)
40-49	455 (26.2%)	620 (26.0%)
50+	133 (8.0%)	284 (11.7%)
Exposure Category		
Sex between men	1,276 (73.4%)	1,881 (78.0%)
Sex between men/IDU	145 (8.3%)	203 (8.4%)
Injection Drug Use	160 (9.2%)	195 (8.0%)
Heterosexual Contact	129 (7.4%)	70 (3.0%)
Hemophilia	5 (0.3%)	8 (0.3%)
Transfusion	6 (0.3%)	18 (0.7%)
Perinatal Transmission	3 (0.2%)	5 (0.2%)
NIR	14 (1.0%)	44 (1.8%)
TOTAL	1,738 (100%)	2,424 (100%)

Geographic Information System

Geographic Information System (GIS) is a computer-based mapping technology, which combines geographical data and events such as a population, disease cases, vital statistics, socioeconomic indicators, and many other data sources to generate maps for spatial analysis. The Health Department uses GIS to monitor the health status of the community by assessing epidemiological data. This analysis determines which diseases and conditions account for the greatest morbidity and mortality in the City which allows for more localized efforts in health promotion and disease prevention efforts.

AIDS surveillance data is used to map cases by geographic location such as zip codes and census tracts in Long Beach. Geographic analysis of data allows for the provision of HIV/AIDS screening and prevention services to be targeted to individuals that are at a greater risk for infection. Mapping AIDS cases in the City may allow for a greater level of targeted outreach in the areas with a higher number of cases. Map 1 demonstrates the cumulative number of reported AIDS cases at time of diagnosis among City residents from 1981 through June 30, 2002 by census tract. This map does not take into the account the migration of individuals with AIDS moving in and out of Long Beach.

MAP 1: Cumulative AIDS Cases By Census Tract Reported 1981 Through June 30, 2002, City of Long Beach



Source: City of Long Beach Department of Health and Human Services, HIV Epidemiology Program.

HIV/AIDS MONITORING REPORT

HIV ANTIBODY TESTING PROGRAM

The Health Department provides both anonymous and confidential HIV antibody testing to the public. HIV antibody testing also occurs through other venues in the City of Long Beach, including private physicians, hospitals and clinics. However, while AIDS is reportable in California, HIV infection is not a reportable condition. Therefore, these data reflect City-administered testing programs only.

The City has maintained data on both anonymous and confidential HIV antibody testing since the programs began. In January 1990, the California Department of Health Services, Office of AIDS implemented the HIV Test Reporting System, a computer program that collects demographics on clients and their test results to generate reports valid to local testing sites and to improve data reporting to the Office of AIDS.

“Data represents each client visit and services provided. The basic tabulated information is this client visit/service unit. A client may have made more than one HIV-related visit; each visit may be reported separately. A client may have received more than one service from different funding sources on the same visit — each reported separately. It is important to keep in mind that these data represent counseling and testing services through these programs and should NOT be interpreted as representing persons or the population of [Long Beach] in general. Recipients of these services are a highly self-selected group.”

California HIV Testing and Counseling Monthly Report, 2/90

Anonymous Testing

The Alternative Test Site (ATS) program was developed for individuals wanting to know their HIV antibody status anonymously. The HIV antibody test administered in an ATS setting addressed the concern that individuals at risk for HIV infection might donate blood to determine their antibody status if blood banks were the only source of free and easily accessible testing. ATS began here in Long Beach in June 1985 and two testing sites currently exist (Table 12 and 13).

TABLE 12

ANONYMOUS HIV ANTIBODY TESTS BY RACE/ETHNICITY AND AGE GROUP, APRIL 1988 THROUGH JUNE 30, 2002, CITY OF LONG BEACH.

	# of Tests	% of Total	# of Pos.	% Pos.
Race/Ethnicity				
White	47,698	56.7%	1,651	3.5%
Black	11,782	14.0%	384	3.3%
Hispanic	18,159	21.6%	623	3.4%
Asian/PI	4,499	5.3%	76	1.7%
Am. Ind./Alaska Nat.	541	0.6%	33	6.1%
Other/Unknown	1,490	1.8%	37	2.5%
Age Group				
12-19	5,255	6.2%	36	0.7%
20-29	34,738	41.3%	1,026	3.0%
30-39	26,331	31.3%	1,143	4.3%
40-49	11,610	13.8%	440	3.8%
50-59	4,145	4.9%	120	2.9%
60+	2,050	2.4%	35	1.7%
Unknown	40	<0.1%	4	10.0%
TOTAL	84,169	100.0%	2,804	3.3%

* Prior to April 1988, no testing data were collected by race/ethnicity or age group.

TABLE 13

ANONYMOUS HIV ANTIBODY TESTS BY GENDER AND EXPOSURE CATEGORY, JUNE 1985 THROUGH JUNE 30, 2002, CITY OF LONG BEACH.

	# of Tests	% of Total	# of Pos.	% Pos.
Gender				
Male	68,799	67.5%	5,016	7.3%
Female	33,046	32.4%	193	0.6%
Other/Unknown	43	<0.1%	0	0.0%
Exposure Category				
MSM	29,060	28.5%	3,923	13.5%
Bisexual	7,335	7.2%	585	8.0%
IDU	3,621	3.6%	93	2.6%
MSM/IDU	867	0.9%	146	16.8%
Hemophiliac	26	<0.1%	4	15.4%
Transfusion Recipient	1,415	1.4%	19	1.3%
Heterosexual	28,502	28.0%	146	0.5%
High Risk Sex Partner	17,250	16.9%	173	1.0%
Occupational	749	0.7%	2	0.3%
No Risk Stated	10,892	10.7%	64	0.6%
Unknown	2,171	2.1%	54	2.6%
TOTAL	101,888	100.0%	5,209	5.1%

Confidential Testing

Confidential testing (CTS) began in 1988; this report reflects data gathered beginning January 1989. These data include individuals tested confidentially for HIV antibody status at the Health Department or through special outreach testing efforts. The confidential testing report includes data collected from

TABLE 14

CONFIDENTIAL HIV ANTIBODY TESTS BY DEMOGRAPHICS, JANUARY 1989 THROUGH JUNE 30, 2002, CITY OF LONG BEACH.

	# of Tests	% of Total	# of Pos.	% Pos.
Gender				
Male	25,483	59.4%	454	1.8%
Female	17,371	40.5%	92	0.5%
Other/Unknown	75	0.2%	3	4.0%
Race/Ethnicity				
White	12,737	29.7%	171	1.3%
Black	14,131	32.9%	228	1.6%
Hispanic	11,848	27.6%	126	1.1%
Asian/PI	2,927	6.8%	12	0.4%
Am. Ind./Alaska Nat.	316	0.7%	4	1.3%
Other/Unknown	970	2.3%	8	0.8%
Age Group				
Under 12	13	<0.1%	0	0.0%
12-19	5,861	13.7%	10	0.2%
20-29	17,510	40.8%	183	1.0%
30-39	10,798	25.2%	229	2.1%
40-49	5,956	13.9%	91	1.5%
50-59	2,050	4.8%	24	1.2%
60+	668	1.6%	11	1.6%
Unknown	73	0.2%	1	1.4%
Exposure Category				
MSM	1,768	4.3%	157	8.9%
Bisexual	1,274	3.1%	83	6.5%
IDU	2,900	7.0%	59	2.0%
MSM/IDU	321	0.8%	48	15.0%
Hemophiliac	1	<0.1%	0	0.0%
Transfusion Recipient	241	0.6%	3	1.2%
Heterosexual	16,978	41.2%	69	0.4%
High Risk Sex Prtnr	9,763	23.7%	91	0.9%
Occupational	214	0.5%	0	0.0%
No Risk Stated	6,620	16.1%	32	0.5%
Unknown	1,155	2.8%	7	0.6%
TOTAL	41,235	100.0%	549	1.3%

tests performed at Health Department clinics.

TECHNICAL NOTES

These data reflect statistical monitoring activities aimed at identifying the entire range of HIV infection in Long Beach.

Data presented in this report are provisional due to reporting delays.

Surveillance and Reporting of AIDS¹

The AIDS Classification System represents cases that have met the AIDS case surveillance reporting criteria established by the Federal Centers for Disease Control and Prevention (CDC) of the Department of Health and Human Services. In September 1992, the CDC proposed the inclusion of three conditions: pulmonary tuberculosis, recurrent pneumonia, and invasive cervical cancer, and HIV-infected adolescents and adults who have CD4+ T-lymphocyte counts less than 200 cells/ μ L or a CD4+ percentage of less than 14, in addition to the clinical conditions listed in the 1987 surveillance case definition. This revised classification was implemented in January 1993. Persons who meet the criteria for more than one definition category are classified hierarchically in the following order: pre-1987, 1987, and 1993. Persons in the 1993 definition category only meet the 1993 definition.

Caution should be used when interpreting monthly statistics, because they can vary month to month due to a variety of factors. Therefore, looking at the long-term trends for a complete analysis of the AIDS data is necessary. Similar caution should be used in the interpretation of small numbers cases, as analyses based on small numbers are more likely to yield incorrect conclusions due to random or systematic error.

Age group tabulations are based on the person's age at diagnosis of AIDS: adult/adolescent cases include persons 13 years of age and older; pediatric cases include children under 13 years of age.

Men who have sex with men (MSM) cases include men who report sexual contact with other men (i.e., homosexual contact) and men who report sexual contact with both men and women (i.e., bisexual contact).

Heterosexual contact cases include persons who report either specific heterosexual contact with a person with (or at increased risk for) HIV infection (e.g., injecting drug use).

Undetermined cases are persons with no reported history of exposure to HIV through any of the routes listed in the hierarchy of transmission categories. These cases include: persons whose exposures are currently under investigation by local health department officials; persons whose exposure history is incomplete because they died, declined to be interviewed, or were lost to follow-up; and persons who were interviewed or for whom other follow-up information was available and no exposure mode was identified. Persons who have an exposure mode identified at the time of follow-up are reclassified into the appropriate exposure category.

Race/Ethnicity² is classified by the individual reporting the AIDS case. Usually, race/ethnicity is self reported by the patient upon enrollment with the health care provider. The definitions below represent those classifications as effectively as possible.

White, Not Hispanic: A person having origins in any of the original peoples of Europe, North Africa or the Middle East.

Black, Not Hispanic: A person having origins in any of the black racial groups of Africa.

Hispanic: A person of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish culture or origin, regardless of race.

Asian/Pacific Islander: A person having origins in any of the original people of the Far East, South East Asia, the Indian subcontinent, or the Pacific Islands. This area includes, for example, China, India, Japan, Korea, the Philippine Islands and Samoa.

American Indian/Alaska Native: A person having origins in any of the original peoples of North American, and who maintains cultural identification through tribal affiliation or community recognition.

Not Specified: Race/ethnicity was not identified and/or reported at the time of diagnosis and report. These cases are currently under investigation. Upon identification of race/ethnicity, cases will be reclassified into the appropriate category.

Incidence rate³ is defined as the number of new cases of a specified disease diagnosed or reported during a defined period of time, divided by the number of persons in a state population in which the cases occurred. This is usually expressed as cases per 1,000 or 100,000 per annum. This rate may be expressed as age- or gender-specific or as specific for any other population characteristic or subdivision.

Prevalence rate³ is defined as the total number of persons sick or portraying a certain condition in a stated population at a particular time, or during a stated period of time, regardless of when that illness or condition began, divided by the population at risk of having the disease or condition at the point in time or midway through the period in which they occurred.

¹ Definitions used here were taken mostly from the CDC HIV/AIDS Surveillance Report, Technical Notes section.

² Federal Register. August 28, 1995. Volume 60, Number 166. Notices, pp. 44692-44693.

³ Control of Communicable Diseases Manual. Abram S. Benenson, Editor. Sixteenth Edition, 1995.

HIV/AIDS RESOURCES**National Hotlines**

AIDS Clinical Trials Information Services	800-TRIALS-A
CDC Hearing Impaired AIDS Hotline (TTY)	800-243-7889
CDC Labor Responds to AIDS Resource Service	800-458-5231
CDC National HIV/AIDS Hotline	800-342-AIDS
CDC Spanish HIV/AIDS Hotline	800-344-7432
CDC National Prevention Information Network	800-458-5231
CDC National STD Hotline	800-227-8922
AIDS Statistical Information Line (Recorded Information)	888-232-3299
Fax Information Service Line	888-232-3299
General Info. (including info on HIV/AIDS) (Recorded Information)	888-232-3299
HIV/AIDS Treatment Information Service	800-HIV-0440
Project Inform (HIV Treatment Hotline)	800-822-7422
National Pediatric HIV Resource Center	800-362-0071

State AIDS Hotlines

California (Southern) (English)	800-922-AIDS
California (Southern) (Spanish)	800-400-SIDA
California (Southern) (TTY/TDD)	800-553-AIDS
California (Northern) (Spanish and English)	800-367-AIDS
California (Northern) (Tagalog)	800-345-AIDS
California (Northern) (TDD)	888-225-AIDS

NOTICE TO HEALTH CARE PROVIDERS AND OTHERS RESPONSIBLE FOR DISEASE REPORTING

California Code of Regulations, Title 17, Section 2500 requires that all diagnosed or suspected cases of AIDS as defined by CDC must be reported within seven (7) days to the Health Officer. To obtain information on the CDC AIDS case definition, to obtain case report forms or to report a case, contact:

City of Long Beach
Department of Health and Human Services
HIV Epidemiology Program
2525 Grand Avenue
Long Beach, CA 90815
Phone (562) 570-4311
www.ci.long-beach.ca.us/health

Ronald R. Arias, M.P.A.
 Director
 Department of Health and Human Services

Darryl Sexton, M.D.
 City Health Officer

Nettie DeAugustine, Manager
 Preventive Health Bureau

John Aguirre, Supervisor
 Epidemiology

Michael Davis
 HIV Epidemiology Program Supervisor

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Hanan Obeidi, M.P.H., C.H.E.S.
 Epidemiology Analyst

Christina Kau, Data Manager
 Preventive Health Bureau

Single copies of this report are available free from the Long Beach Department of Health and Human Services, Preventive Health Bureau, HIV Epidemiology Program, 2525 Grand Avenue, Long Beach, CA 90815; telephone (562) 570-4311. Individuals or organizations can be added to the mailing list by writing to the same address as mentioned above. This information is available in an alternative format by request to Sarady Kong at (562) 570-4341.



HIV/AIDS Monitoring Report

City of Long Beach
Department of Health and Human Services
HIV Epidemiology Program
2525 Grand Avenue
Long Beach, CA 90815

HE1207-03

HIV/AIDS MONITORING REPORT

Attention Health Care Providers

The California Code of Regulations, Title 17, Section 2500, requires the report of communicable diseases and conditions. To report a case of a communicable disease, contact the City of Long Beach Department of Health and Human Services Epidemiology Program at 562-570-4302 or by fax at 562-570-4374.

Reportable Communicable

Diseases	Dengue ☞	Listeriosis ☞FAX	Rocky Mountain Spotted Fever	Typhus Fever
HIV/AIDS ☞	Diarrhea of the Newborn ☞	Lyme Disease	Rubella (German Measles)	Varicella (deaths only) ☞
Amebiasis ☞FAX	(Outbreaks)	Lymphocytic Choriomeningitis ☞FAX	Rubella Syndrome, Congenital	<i>Vibrio</i> Infections ☞FAX
Anisakiasis ☞FAX	Diphtheria ☞	Malaria ☞FAX	Salmonellosis ☞FAX	Viral Hemorrhagic Fevers ☞
Anthrax ☞	Domoic Acid Poisoning ☞	Measles ☞FAX	Scombroid Fish Poisoning ☞	Water-associated Disease ☞FAX
Babesiosis ☞FAX	Echinococcosis	Meningitis ☞FAX	Shigellosis ☞FAX	Yellow Fever ☞
Botulism ☞	Ehrlichiosis	Meningococcal Infections ☞	Smallpox (variola) ☞	Yersiniosis ☞FAX
Brucellosis ☞	Encephalitis ☞FAX	Mumps	Streptococcal Infections ☞FAX	OCCURRENCE of ANY
Campylobacteriosis ☞FAX	<i>Escherichia coli</i> O157:H7 ☞	Non-Gonococcal Urethritis	(Outbreaks of Any Type and Individual Cases in Food Handlers and Dairy Workers Only)	UNUSUAL DISEASE ☞
Chancroid	Foodborne Disease ☞FAX †	Paralytic Shellfish Poisoning ☞	Swimmer's Itch ☞FAX	OUTBREAKS of ANY DISEASE ☞
Chlamydial Infections	Giardiasis	Pelvic Inflammatory Disease	Syphilis ☞FAX	<u>Reportable Noncommunicable</u>
Cholera ☞	Gonococcal Infections	Pertussis (Whooping Cough) ☞FAX	Tetanus	<u>Diseases/Conditions</u>
Ciguatera Fish Poisoning ☞	<i>Haemophilus Influenzae</i> ☞FAX	Plague, Human or Animal ☞	Toxic Shock Syndrome	Alzheimer's Disease
Coccidioidomycosis	Hantavirus Infections ☞	Poliomyelitis, Paralytic ☞FAX	Toxoplasmosis	Cancer
Colorado Tick Fever ☞FAX	Hemolytic Uremic Syndrome ☞	Psittacosis ☞FAX	Trichinosis ☞FAX	Disorders Characterized by
Conjunctivitis, Acute Infectious of the Newborn ☞FAX	Hepatitis, Viral ☞FAX	Q Fever ☞FAX	Tuberculosis ☞FAX	Lapses of Consciousness
Cryptosporidiosis ☞FAX	Kawasaki Syndrome	Rabies, Human or Animal ☞	Tularemia ☞	
Cysticercosis	Legionellosis	Relapsing Fever ☞FAX	Typhoid Fever ☞FAX (Cases and Carriers)	
	Leprosy	Reye Syndrome		
	Leptospirosis	Rheumatic Fever, Acute		

☞FAX = Report by FAX, telephone, or mail within one (1) working day of identification.

† = Report immediately by telephone when two (2) or more cases or suspected cases of foodborne disease from separate households are suspected to have the same source of illness.

☞ = Report immediately by telephone.
All other diseases/conditions should be reported by FAX, telephone, or mail within seven (7) calendar days of identification.